**Medical Certificate (Driving license)**

**Registration Number ..………………...**

**Part 1**

**To be filled by applicant**

**Name (Mr./Mrs./Miss) .......................................................................................................................................................**

**Residential address with postal code ..............................................................................................................................**

**...........................................................................................................................................................................................**

**Identification number** □-□□□□-□□□□□-□□-□,

**I do apply for medical certificate with my health history as follows**

**1. My personal specific disease** □ **No** □ **Yes (please specify)..............................................................**

**2. Accident or Surgery** □ **No** □  **Yes (please specify).............................................................**

**3. Hospital Admission** □ **No** □ **Yes (please specify)..............................................................**

**\*4. Seizure** □ **No** □ **Yes (please specify)..............................................................**

**5. Other relevant ..............................................................................................................................................................**

**Signature...................................................**

**Date......................................(D/M/Y)**

*\*Seizure: treatment history produced by doctor in charge must be accompanied to certify that no attack experienced within 1 (one) year.*

**Part 2**

**To be filled by doctor**

**(1)**

**Place of examination (Hospital / Clinic) with postal code ...............................................................................................** **...........................................................................................................................................................................................**

**I’m, Dr. ..............................................................................................................................................................................**

**medical practice license No…...........................................................................................................................................** **Residential address with postal code .............................................................................................................................. ...........................................................................................................................................................................................**

**I had examined(Mr./Mrs./Miss).............................................on date...................month.......................year.....................** **and revealed as follows bodyweight..................kgs. Height....................cms. Blood pressure...........................mmHg, pulse rate................../min**

**General Physical Condition** □ **Normal** □ **Abnormal (please specify) ........................................................................**

**I,hereby,certify that the above person is capable to work, no mental disability or mental retardation** **nor showing of any symptom of drug addiction nor chronic alcoholism and no sign and symptom of the** **followings:**

1. **Leprosy at contagious or symptomatic stage**
2. **Contagious stage of Tuberculosis**
3. **Symptomatic Elephantiasis**
4. **Others**

**(2)**

**Physician Conclusion / Advice..........................................................................................................................................**

**...........................................................................................................................................................................................**

**Signature.................................................M.D.**

**Date............................................(D/M/Y)**

**N.B.** *(1) This form must be certified only by licensed medical practitioner*

1. *Must conclude fitness of applicant.*
2. *This certificate is valid within 1 month from the day of application.*
3. *This medical certification applies only for provisional diagnosis and covers only application for driving license and vehicle operators.*

*This certification form had been approved by the Thai Medical Council at its 6/2021 meeting on May, 13, 2021*